



Reimbursement fast facts: ventilators

Understanding Medicare coding and coverage

Ventilators are medical devices that provide mechanical ventilation to assist with or replace patients' spontaneous breathing. Mechanical ventilation is often categorized by the interface used, such as a tracheostomy tube for invasive ventilation, or a mask for non-invasive ventilation.

Device	Description	HCPCS code	2019 Medicare Reimbursement ¹
Home ventilator: Invasive	Home ventilator, any type, used with invasive interface (e.g. tracheostomy tube)	E0465	\$1,099–\$934 (monthly rate)
Home ventilator: Non-invasive	Home ventilator, any type, used with non-invasive interface (e.g. mask, chest shell)	E0466	

Billing criteria for ventilators

Ventilators are covered by Medicare for the treatment of neuromuscular diseases, thoracic restrictive diseases and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

Ventilators are included in Medicare's "Frequently & Substantially Serviced" payment category. Equipment in this payment category is paid on a monthly rental (RR) basis while the equipment is medically necessary. No payment is made by Medicare for the purchase of equipment, maintenance and servicing, or for the replacement of items in this category. Due to the "Frequently & Substantially Serviced" payment category, no separate payment is allowed for ventilator accessories or supplies under the Medicare Program.²

Documentation to support the medical necessity of a ventilator may include:

- Valid prescription (order)³ that includes:
 - Beneficiary's name
 - Date of the order
 - A general description (e.g. wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number of all items separately billed
 - Prescribing practitioner's signature, date and NPI
 - For separately billed supplies: frequency of use (if applicable), and the quantity dispensed
- Payable diagnosis
- Medical necessity documented in the medical record
- Ventilator settings

- Documentation describing the supplier's backup plan in case the primary ventilator breaks down
- Proof of delivery⁴

Documentation to support continued medical need must also be on file (see Q&A).

When should a ventilator or respiratory assist device (RAD) be considered?

Ventilators are covered for neuromuscular diseases, thoracic restrictive diseases and chronic respiratory failure consequent to chronic obstructive pulmonary disease (COPD).

These ventilator-related disease groups overlap conditions described in the respiratory assist devices LCD used to determine coverage for bilevel positive airway pressure (PAP) devices. Each of these disease categories are conditions where the specific presentation of the disease can vary from patient to patient. For conditions such as these, the specific treatment plan for any individual patient will vary as well. Choice of an appropriate treatment plan, including the determination to use a ventilator vs. a BiPAP device, is made based upon the specifics of each individual beneficiary's medical condition. In the event of a claim review, there must be sufficiently detailed information in the medical record to support the treatment selected.²



Q & A

Q: What additional items are typically supplied to ventilation patients?

Since ventilators are covered under the “Frequently & Substantially Serviced” payment category, bills for supplies and accessories are not separately allowed. However, other items may be medically necessary. Depending on the patient’s condition, items like oxygen, nebulizers, suction machines and tracheostomy supplies may also be provided. Please check with your payor to confirm coverage and billing details.

Q: Are humidifiers separately reimbursable?

No, under the “Frequently & Substantially Serviced” payment category, humidifiers are bundled into the ventilator reimbursement and are *not* separately billable. When a ventilator is purchased by the beneficiary or acquired before Medicare eligibility, separate reimbursement may be considered. Verify coverage with payor prior to billing.

Q: Is a face-to-face meeting required prior to writing a detailed written order for a ventilator?

Yes, ventilators are included in the list of DME items that require a face-to-face encounter examination with a beneficiary in the six (6) months prior to the written order.⁵

Q: Can a supplier bill for a positive airway pressure (PAP) device in addition to a ventilator?

If both a ventilator and a PAP device (E0601, E0470, E0471) are billed, the PAP device will be denied as not medically necessary.

Q: Can a supplier bill for a second ventilator or a backup ventilator?

Medicare does not cover spare or back-up equipment but will make a separate payment for a second piece of equipment if it is required to serve a different medical purpose that is determined by the beneficiary’s medical needs.²

Examples of situations in which multiple items may be covered (not all-inclusive):

- A beneficiary requires one type of ventilator (e.g. a negative pressure ventilator with a chest shell) for part of the day and needs a different type of device (e.g. positive pressure RAD with a nasal mask) during the rest of the day.

- A beneficiary who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day, and needs another ventilator of the same type for use while in bed. Without both pieces of equipment, the beneficiary may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

Q: What documentation can be used to prove continued medical need?

Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating practitioner for refills
 - A recent change in prescription
 - A properly completed Certificate of Medical Necessity (CMN) or DME Information Form (DIF) with an appropriate length of need specified
 - Timely documentation in the beneficiary’s medical record showing usage of the item (e.g. progress note)
- “Timely documentation” is defined as a record in the preceding twelve (12) months unless otherwise specified elsewhere in the policy.

Q: Does Medicare cover repairs or maintenance for ventilators?

Ventilators fall into the “Frequently & Substantially Serviced” payment category, and neither repairs nor maintenance and servicing are covered.

For more information on RADs, please reference:

- ResMed RAD Guidelines, PN [1010293](#)
- ResMed RAD Reimbursement Fast Facts, PN [1013495](#)
- CMS’ RAD LCD ([L33800](#)) effective date 10/1/2015

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¹ Rates are based upon the Medicare January 2019 DMEPOS Fee Schedules. Actual allowable varies by state. Retrieved online Jan 15, 2019 ² Palmetto GBA, LLC. Joint DME MAC Publication. Correct Coding and Coverage of Ventilators – Revised January 2019. Retrieved online Jan 14, 2019 ³ U.S. Centers for Medicare & Medicaid Services. Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426) (Rev. eff. Date 08/28/2018). Retrieved online Jan 16, 2019 ⁴ U.S. Centers for Medicare & Medicaid Services. DMEPOS Enrollment. DMEPOS Supplier Standards. Retrieved online Jan 15, 2019 ⁵ MLN Matters® Number: MM8304; July 1, 2013

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